

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011540

STATE FILE NUMBER

2-3104

Registration District No.

Primary Registration District No.

Registrar's No.

FILED APR 10 1959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis TOWN		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location and length of stay in lb) HOSPITAL OR INSTITUTE St. Louis, Little Rock Hospitals, Inc.		d. STREET ADDRESS 4415 Nebraska (If outside, give location)	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gustav Middle Last Wolf		4. DATE OF DEATH Month March Day 27 , Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1881
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	
11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE Frances Wolf			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 420-0	
17. INFORMANT Frances Wolf		Address 4415 Nebraska Ave. St. Louis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerosis of H. R. Ar. DUE TO (c) Arteriosclerosis, gen'l. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Prostatic Hypertrophy			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) 420-0	
20c. TIME OF INJURY Hour 3:50 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION St. Louis		20f. COUNTY St. Louis	
20g. STATE Mo.			
21. I attended the deceased from Death occurred at 3:50 AM on the date stated above; and to the best of my knowledge, from the causes stated.		22. ADDRESS 1755 South Grand Ave.	
22a. SIGNATURE Charles Kromer, M.D. (Degree or title)		22b. DATE SIGNED 3/27/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 30-1959	
23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.	
24. FUNERAL DIRECTOR Gebken-Benz		25. DATE RECD. BY LOCAL REG. MAR 27 '59	
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. Must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4249

P. O. Address 7847 McNamee

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.